

AWANA FAMILY REGISTRATION 2008/2009

"APPROVED MEN AND WOMEN ARE NOT ASHAMED..." 2 TIMOTHY 2:15

PARENT INFORMATION

Please use **BLUE** or **BLACK** ink.

FATHER'S FULL NAME		MOTHER'S FULL NAME	
ADDRESS		ADDRESS (if diff.)	
CITY, STATE, ZIP		CITY, STATE, ZIP	
HOME PHONE		HOME PHONE	
WORK/CELL PHONE		WORK/CELL PHONE	
E-MAIL ADDRESS		E-MAIL ADDRESS	

CHILD INFORMATION

CHILD'S FULL NAME	SEX	BIRTHDAY	GRADE	CLUB	CHURCH ATTENDING
1.	M F				
2.	M F				
3.	M F				
4.	M F				

AMOUNT DUE

CLUB	COST	QTY.	SUBTOTAL
CUBBIES (3-4 YEAR OLDS. THIS IS ONLY A 2 YEAR PROGRAM. CHILDREN SHOULD BE ENTERING KINDERGARTEN THE SAME YEAR THEY FINISH CUBBIES)	\$30.00		
SPARKS (K-2 nd GRADE)	\$30.00		
T&T (3 rd -6 th GRADE)	\$30.00		
TOTAL DUE:			

- Children will use same uniform as last year, unless changing clubs (ex. Cubbies to Sparks or Sparks to T&T)
- Registration fee includes book, club costs, activities, awards, etc.

OFFICE USE ONLY

TOTAL: _____
 CASH: _____
 CHECK: _____ # _____
 DATE RCVD: _____

PLEASE FILL OUT THE BACK SIDE ⇨

EMERGENCY MEDICAL TREATMENT

AUTHORIZATION TO CONSENT TO EMERGENCY MEDICAL TREATMENT

(I), (WE), THE PARENTS/GUARDIANS OF THE CHILDREN LISTED ABOVE DO HEREBY AUTHORIZE THE SPONSOR REPRESENTING NEW HOPE CHURCH, AS AGENT FOR THE UNDERSIGNED TO CONSENT TO ANY X-RAY EXAMINATION, ANESTHETIC, MEDICAL OR SURGICAL DIAGNOSIS OR TREATMENT AND HOSPITAL CARE WHICH IS DEEMED ADVISBLE BY, AND IS TO BE RENDERED UNDER GENERAL OR SPECIAL SUPERVISION OF, ANY PHYSICIAN AND SURGEON LICENSED UNDER THE PROVISIONS OF THE MEDICAL PRACTICE ACT ON THE MEDICAL STAFF OF A LICENSED HOSPITAL, WHETHER SUCH DIAGNOSIS OR TREATMENT IS RENDERED AT SAID HOSPITAL.

IT IS UNDERSTOOD THAT THIS AUTHORIZATION IS GIVEN IN ADVANCE OF ANY SPECIFIC DIAGNOSIS, TREATMENT, OR HOSPITAL CARE REQUIRED BUT IS GIVEN TO PROVIDE AUTHORITY AND POWER ON THE PART OF AFORESAID AGENT TO GIVE SPECIFIC CONSENT TO ANY AND ALL SUCH DIAGNOSIS, TREATMENT AND HOSPITAL JUDGEMENT MAY DEEM ADVISABLE.

THIS AUTHORIZATION IS GIVEN PURSUANT TO THE PROVISION OF SECTION 25.8 OF THE CIVIL LIBERTIES CODE OF MINNESOTA. THIS AUTHORIZATION IS TO BE EFFECTIVE UNTIL IT IS REVOKED, IN WRITING TO SAID AGENT.

IT IS UNDERSTOOD THAT, AS PARENTS OR GUARDIANS, WE ARE RESPONSIBLE FOR ALL MEDICAL COSTS AND (I), (WE) WILL NOT HOLD NEW HOPE CHURCH, THE LEADER, ANY OFFICER, DRIVERS, OR HELPERS LIABLE FOR MEDICAL AID RENDERED TO MY CHILD(REN).

SIGNATURE OF PARENT/LEGAL GUARDIAN _____ DATE: _____

.....
NAME OF FAMILY DOCTOR _____ PHONE# _____

INSURANCE COMPANY: _____ MEMBER OR POLICY# _____

*ALL KNOWN ALLERGIES/SPECIAL INFORMATION _____

DATE OF LAST TETNUS SHOT: CHILD #1 ____/____/____ CHILD #2 ____/____/____

CHILD#3 ____/____/____ CHILD #4 ____/____/____

My permission is given to NHC Children's Ministries to use pictures of my child(ren) during church events and functions in publications, promotions, bulletin boards, etc.

Parent's Signature _____ Date ____/____/____